

## Timor-Leste Health Improvement Project

# Building Capacity to Improve Maternal, Newborn, and Child Health and Family Planning Outcomes

The United States Agency for International Development (USAID) supports the **Health Improvement Project, known locally as HADIAK**, as part of the overall United States Government package of assistance to Timor-Leste. HADIAK is a technical assistance project supporting the Ministry of Health (MOH) in the areas of maternal, neonatal and child health (MNCH) and family planning (FP) programming. HADIAK's capacity building assistance is delivered at the national level (MOH), municipality level (municipality health services–MHS), administrative post level (community health centers–CHCs), and community level (health posts–HPs and integrated community health services–SISCa) to benefit health workers and communities through mentoring and training. Implementation focuses on the municipalities of Ermera, Manatuto, and Oecusse.

## INTRODUCTION

The USAID–supported Timor-Leste Health Improvement Project (TL-HIP) with additional support provided by the Australian Department of Foreign Affairs and Trade (DFAT), used a holistic capacity building approach to achieve measurable impact in maternal, child, and newborn health (MCNH) and family planning (FP) outcomes. The cornerstone of HIP's approach was providing technical assistance to strengthen people, systems, organizations, and communities by capitalizing on local resources, inclusive partnerships, and appropriate adaptations to the local context.

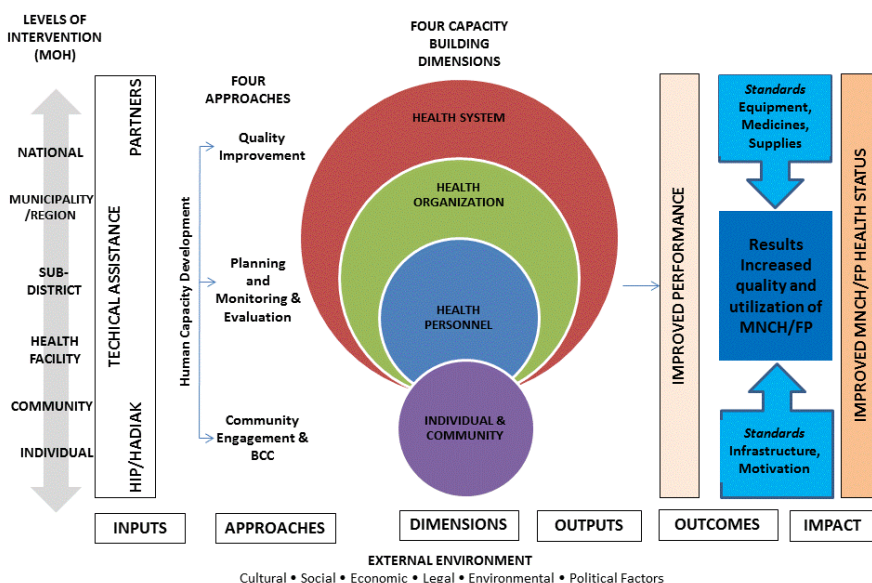
## APPROACH: FRAMING CAPACITY BUILDING IN HIP

HIP defined capacity building as “a process that improves the ability of a person, group, organization, or system to meet objectives or to perform better.”<sup>1</sup> It suggests that no single approach is sufficient. Rather, enabling effective health promotion, service provision, and service utilization requires the simultaneous and continuous development of people, systems, structures, and functions.

An improved health outcome depends on a well-performing health system, which in turn depends on the capacity of the system and individuals *within* and *connected* to that system to perform well. To address these multiple levels and functions, HIP simultaneously focused on health system functions, health staff ability to perform their work functions, and individual ability to engage with the health system to access services.

To achieve this, HIP drew upon a conceptual framework outlined by previous work done

**Figure 1: Conceptual Framework for Capacity Building**

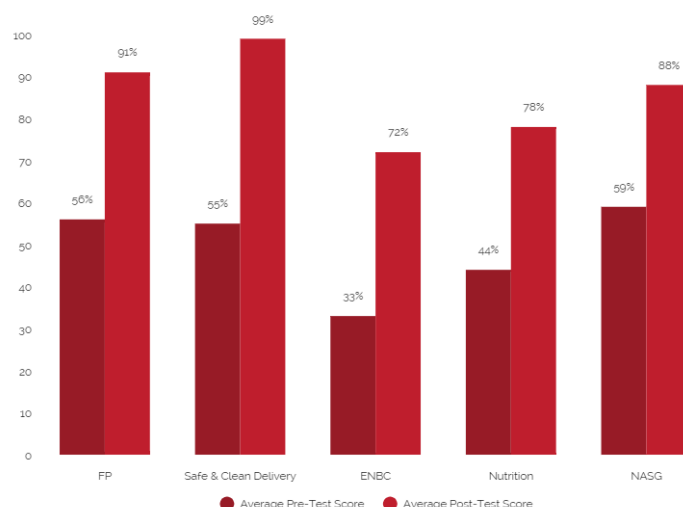


by USAID through MEASURE Evaluation<sup>2</sup> around capacity building in health sector assistance programs. The framework, adapted to reflect the HIP approach, maps the core elements and linkages needed to improve MNCH/FP health status (Figure 1).

HIP's technical assistance inputs provided directly to Ministry of Health (MOH) and community counterparts was integrated into every project activity. This facilitated skills strengthening among those ultimately responsible for ensuring system sustainability. It also built directly upon existing structures and MOH tools to ensure parallel systems that were not sustainable beyond the life of the project were not created.

These investments resulted in improved systems and individual capacity to increase the quality and utilization of health services. Sustained over time, improved health status at the population level can be achieved.

**Figure 2: Difference in pre-test and post-test training scores from a sample of 83 trainings implemented by INS and HIP**



## **A CLOSER LOOK AT CAPACITY BUILDING IN ACTION**

The following provides illustrations of how HIP utilized capacity building approaches to develop and strengthen each of the four key capacity building dimensions outlined in the conceptual framework.

### ***Health Personnel Dimension***

Human resources in the health sector - such as health care providers, health facility managers, health advocates, and other health system support personnel - are critical to any capacity building or change process. For a health system to work effectively, a sufficient number of motivated staff with appropriate competencies is needed. Therefore, capacity development of health personnel is at the core of all HIP activities.

HIP's strategic approach underscored the fact that for health personnel to be effective they must first have the knowledge and skills to perform managerial, technical, and support roles. Second, they must be in an environment with appropriate supplies and materials to perform their work. For this reason, capacity strengthening among health personnel was approached both as discrete training activities as well as integrated into all collaborative work used to address other systems, organizational, and individual/community dimensions.

To strengthen human capacity via training, HIP used a collaborative approach by coordinating all in-service training with the Maternal Child Health (MCH) Department and the National Health Institute (INS—*Instituto Nacional de Saúde*), using only INS-approved materials to ensure consistency across national guidelines and protocols.

Critical to strengthened human capacity is improved knowledge and skill development. Using a quality improvement approach, HIP administered pre-test and post-test questionnaires to over 1,700 health personnel trained in more than 60 training sessions to ensure knowledge levels were achieved. As a result, improvements in knowledge and skill levels were noted. For example, in a sample of family planning (FP), safe and clean delivery, essential newborn care (ENBC), nutrition, and non-pneumatic anti-shock garment (NASG) trainings, post-test training scores improved by an average of 35% (range of 29% to 44% increase in scores).

In order to ensure identified skills were acquired, provider competency was assessed post-training using the MOH

*Follow-Up After Training (FUAT)* checklist. With the support of HIP, 454 supportive supervision visits for FP, Safe Motherhood (SM) and ENBC, Expanded Program on Immunizations (EPI), and Integrated Management of Childhood Illnesses (IMCI) were implemented throughout the life of the project. These supportive supervision results showed improvements in the correct use of a partograph, correct prescription for antibiotics, adherence to infection prevention requirements, improved safe delivery skills, and appropriate application of feeding assessments performed on children less than 2 years of age with anemia or low weight.

Increased capacity of health personnel to provide FP counseling as well as improved competency in skills for implant and IUD insertion, for example, can improve both the demand for and utilization of FP services. One result of these efforts that can be seen is an uptake of services, demonstrated in both the increase in the number of FP counseling visits made as well as improvements in Couple Years of Protection (CYPs) over the life of the project.

While individuals can function independently, the other system components – such as providing health care services, managing a health facility, and ensuring quality practices, procedures, and protocols, are followed – require a human element to do so.

Therefore, while direct training approaches utilized by the project were critical to strengthening health personnel capacity as a discrete dimension, the project's approach also ensured that on-going coaching and mentoring were integrated into the other systems, organizations, and individual/community dimensions as well.

### **Health Systems Dimension**

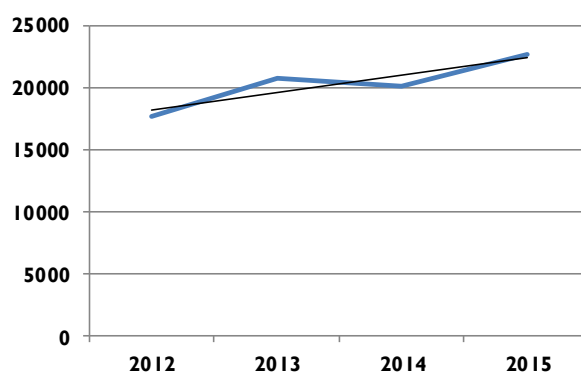
The health systems dimension includes the personnel, resources, planning, and institutions or organizations related to financing, regulation, or the provision of health care which guides health service delivery and health promotion.<sup>3,4</sup> HIP's technical assistance focused on collaborating with MOH, INS, and other relevant partners to ensure the appropriate and necessary policies, protocols, tools, and guidelines needed to improve MNCH/FP outcomes and behaviors were developed and disseminated.

For example through HIP's quality improvement approach, HIP provided intensive assistance to the MOH's Family Planning Unit and Quality Control Cabinet to strengthen its Logistics Management Information System (LMIS) to improve the availability and use of data for contraceptive supply chain management and reduce stock outs of essential contraceptive commodities.

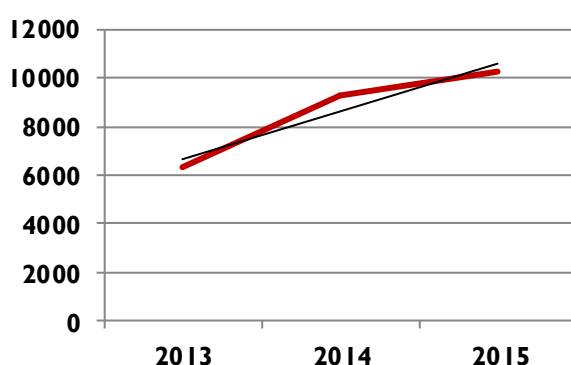
Through the planning, monitoring, and evaluation approach, HIP also collaborated with the MOH's Planning and M&E Department to promote and support evidence-based planning at national, municipality, administrative post, and suco levels. This included the development of the *Health Planning and Budgeting Guidelines* and new planning templates at the national level to facilitate the overall process.

Technical Working Groups (TWGs) on FP, MCH, immunization, and nutrition at the municipality/region, sub-district, and administrative post levels were also established through HIP's participation in the National Health Sector Coordination Committee (NHSCC). TWGs were tasked with monitoring the implementation of the annual plans as well as coordinating Ministry, partner, and donor activities in their respective areas.

**Figure 3: Family Planning Counseling Visits**



**Figure 4: Couple Years of Protection (CYPs)**



These technical assistance efforts resulted in improved system-wide capacity to identify causes of stock out problems and develop solutions to improve contraceptive availability, particularly at the municipal/regional level where most stock outs were occurring. Additionally, there was increased systematic use of existing data to plan and cost activities at all levels which improved capacity to address gaps and strengthen facility readiness and coverage.

### Health Organization Dimension

The health organization includes the structures, processes, and systems in place that allow the organization to produce goods and services, such as quality of care, at an acceptable standard.<sup>5</sup> Within the scope of HIP activities, this primarily refers to the ability of health facilities to deliver high quality health services. HIP's technical assistance focused on strengthening the organizational and management capacity of facilities to ensure that a basic package of quality MNCH/FP services was offered.

HIP operationalized the quality improvement approach by providing intensive technical assistance to the MOH and facilities to implement the MOH's Facility Readiness Format, a checklist to determine if a facility meets basic service package standards. The checklist guides the facility in not only ensuring the delivery of quality basic services but also builds the capacity of facility personnel to plan for improvements, address gaps, and allocate needed resources.

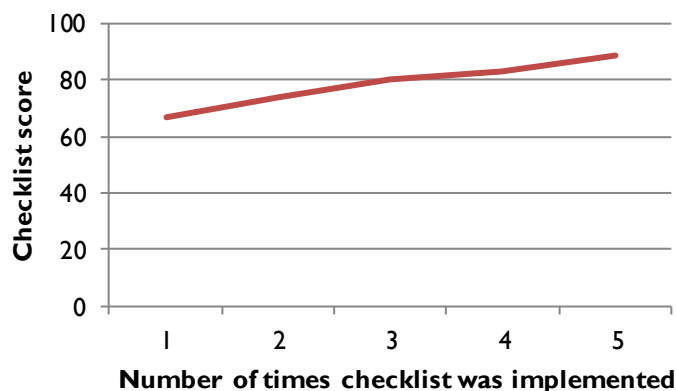
Regular checklist implementation also allowed for monitoring the facility over time to ensure that basic standards were consistently achieved. For example, in Letefoho Community Health Center (CHC) the facility received a score of only 67% at baseline, below the minimum of 75% needed to achieve basic service standards. The checklist identified below standard components, allowing facility management and personnel to quickly identify areas for improvements in resource allocation and planning. Subsequent implementation showed a continuous trajectory of improvement at this CHC over time.

In Atsabe CHC, while an initial score of 74% indicated basic service standards were being met, a follow-up score of 62% represented a significant drop. Through technical assistance in planning and resource allocation, HIP helped the CHC personnel identify where gaps had emerged and develop plans to address them accordingly. Subsequent monitoring showed continuous improvements of almost 90%.

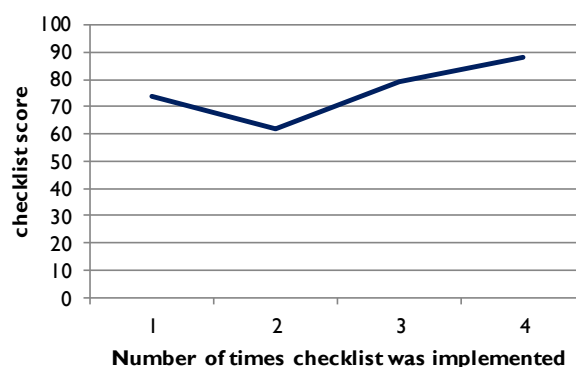
Using the planning, monitoring and evaluation approach, HIP also worked to develop capacity among CHC staff to implement the micro-planning tool. The tool - initially developed by the World Health Organization (WHO) for immunization - was expanded to include antenatal care (ANC), skilled birth attendance (SBA), postnatal care (PNC), and FP. The tool promoted a targeted, bottom-up, participatory, action-oriented process, guiding facility staff to use data to identify and address gaps in health service delivery. Community leaders, organizations, and community-based health promoters are also involved in analyzing the information, setting priorities, and the action planning process.

Through these technical assistance efforts, 16 CHCs improved organizational capacity to plan and address service gaps to increase coverage of essential MNCH services. One key result is improved coverage for immunization of children

**Figure 4: MOH Checklist Scores at Implementation for Letefoho CHC**



**Figure 5: MOH Checklist Scores at Implementation for Atsabe CHC**



under-one year of age of at least 80%. For example, in the three target municipalities of Ermera, Manatuto, and Oecusse over 83%<sup>6</sup> of children were immunized in 2015. In addition, over 253 technical assistance visits for the Facility Readiness Format were completed over the life of the project.

### Individual and Community Dimension

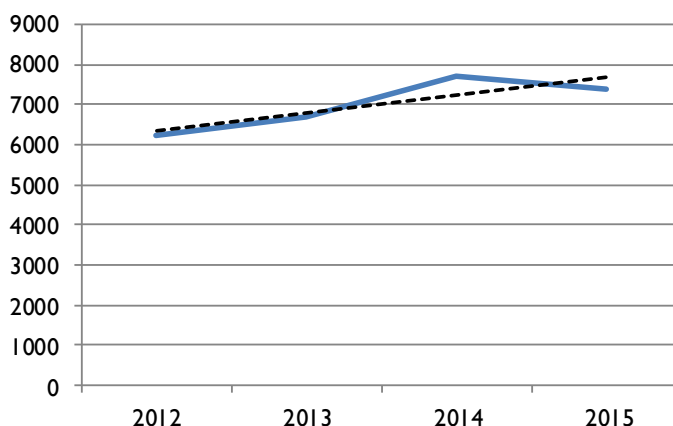
While individuals are essential to improving their own health status, they can also play an important role in shaping health systems. Community engagement to increase demand for MNCH/FP services through a focus on individual education as well as training of local leaders to identify community needs and secure local resources to address problems helped HIP build individual and collective action.

A key example of HIP's community engagement was the implementation of the Maternal Health Community Study with the MCH Department and INS to examine the individual and community factors affecting delays in deciding to seek care, reaching care, and receiving care for obstetric emergencies. In responding to the study results provided to each of the project municipalities/region, Municipality/Region *Action Plans* were developed by municipality leaders, Public Health Officers, and staff from health facilities. The joint planning process provided an opportunity to consider the implications of the study, identify community resources to address gaps, and strengthen collaboration between community leaders and health providers.

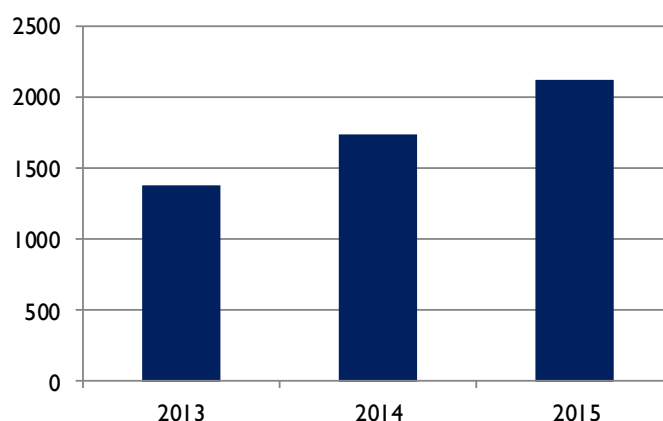
Action plans developed at the municipal/regional level were subsequently used in the MOH Annual Planning and Budgeting Cycle to develop the *2016 Annual Implementation Plan (AIP)*. The action plans provided an evidence-based argument for resourcing the activities necessary to address the factors contributing to delays in seeking, reaching, and receiving care. As a result, the municipality/region-specific AIPs focused on increasing the demand for services to support safe motherhood and on improving the quality of treatment received at health facilities. These activities will be funded in the 2016 health budget.

Another example of HIP's community engagement approach was community monitoring and tracking of safe motherhood and childhood immunization. Suco councils and Family Health Promoters (PSFs—*Promotores Saude Familia*) utilized a HIP-developed enumeration tool to identify and count pregnant women planning to deliver at home or others not receiving ANC and link this list with the midwife's Local Area Monitoring (LAM) register. HIP then supported suco councils and nearby facilities to organize health promotion events such as group discussions on

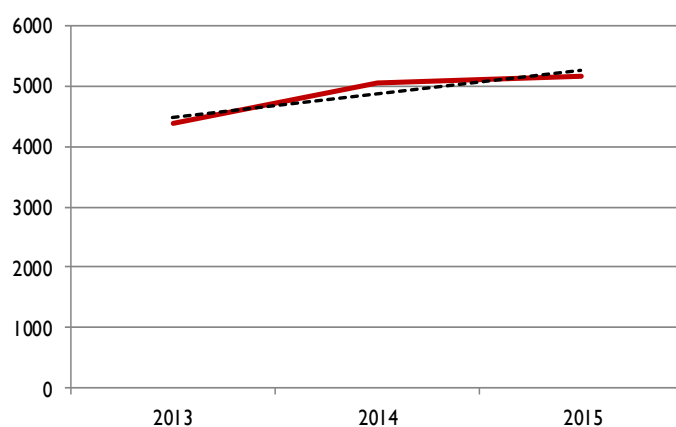
**Figure 6: Number of Children Who Received DPT3 by 12 Months of Age**



**Figure 7: Number of Skilled Deliveries at Health Facilities**



**Figure 8: Number of Pregnant Women Receiving at Least 4 ANC Checks**





preparing for safe motherhood to target these areas. A total of 1,317 people attended group discussion activities, including 603 pregnant women.

Additionally, the community element of the micro-plans developed by CHCs in collaboration with local community organizations and leaders was implemented. During 116 quarterly planning meetings, HIP supported 49 night/day events, 147 Integrated Community Health Services (SISCAs—*Servisu Integradu da Saude Comunitaria*), 53 outreach sessions, and 101 group discussions in the project target districts. During some of these sessions, ANC and PNC services, nutrition services, and immunizations to pregnant women and children under-one year were also provided.

The cumulative effect of these efforts in community engagement resulted in improved coverage results over the life of the project. For example, from 2013 to 2015 skilled deliveries at health facilities steadily increased from 1,386 to 2,219 in project areas. The number of women utilizing ANC services also increased in project target areas from 4,380 pregnant women receiving at least 4 ANC visits in 2013 to 5,162 pregnant women in 2015.

In addition to coverage improvements, efforts have also resulted in improved community capacity to identify and prioritize needs. For example, as infrastructure improvements became an integral part of the implementation of health action plans, a number of suco councils prioritized health facility improvements in their coverage area in order to increase usage and benefits of health facilities. These factors also had a simultaneous effect on increasing coverage for skilled birth deliveries and ANC visits for example.

## **CONCLUSION**

It has become increasingly evident that for health sector programming that there is no “one size fits all” approach, particularly when addressing capacity building. Given the dynamic, non-linear, and multidimensional nature of the concept itself, priorities can change one - or multiple - times throughout the life cycle of a project. This requires the approach to be able to adapt quickly to shifting contexts, needs, and priorities.

HIP’s flexible framework to provide technical assistance through collaborative partnerships with the MOH and other key Ministry partners allowed the project to be responsive to the changing environment. When MOH priorities changed or emerged, HIP already had established relationships through which to be responsive. For example, when the Ministry of Health’s *Facility Readiness Format* checklist became available, HIP’s existing strong partnership allowed the checklist to be immediately piloted in a project municipality and later quickly scaled-up nationally.

While a number of factors were outside the project’s manageable interests, such as the availability of equipment, medicines, and supplies for example, there is clear evidence of increasing coverage of key FP and MCH indicators. Though capacity development is a long-term endeavor, improved system performance to provide services as well as individual performance in accessing services can achieve measurable impact at all levels.

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1. LaFond, Anne and Brown, Lisanne. *A Guide to Monitoring and Evaluation of Capacity-Building Interventions in the Health Sector in Developing Countries*. MEASURE Evaluation Manual Series, No. 7 Carolina Population Center, University of North Carolina at Chapel Hill. 2003.
  2. JSI is an implementing partner of MEASURE. See: <http://www.cpc.unc.edu/measure/>.
  3. LaFond, Anne and Brown, Lisanne. *A Guide to Monitoring and Evaluation of Capacity-Building Interventions in the Health Sector in Developing Countries*. MEASURE Evaluation Manual Series, No. 7 Carolina Population Center, University of North Carolina at Chapel Hill. 2003.
  4. *Everybody's business. Strengthening health systems to improve health outcomes: WHO's framework for action*. WHO. 2007.
  5. LaFond, Anne and Brown, Lisanne. *A Guide to Monitoring and Evaluation of Capacity-Building Interventions in the Health Sector in Developing Countries*. MEASURE Evaluation Manual Series, No. 7 Carolina Population Center, University of North Carolina at Chapel Hill. 2003.
  6. Based on a target population of 8,931 and DPT3 instances of 7,382 in 2015.

### **For More Information:**

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